Minutes of the special meeting of the Board of Directors of the Cook County Health and Hospitals System held Wednesday, October 7, 2009 at the hour of 9:00 A.M. at 1900 W. Polk Street, in the second floor student lounge, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Batts called the meeting to order at approximately 9:50 A.M.

Present: Chairman Warren L. Batts, Vice Chairman Ramirez and Directors David A. Ansell, MD, MPH; David Carvalho; Quin R. Golden; Benn Greenspan, PhD, MPH, FACHE; Sister Sheila Lyne, RSM; Luis Muñoz, MD, MPH; Heather E. O'Donnell, JD, LLM; and Andrea Zopp (10)

Absent: Director Hon. Jerry Butler (1)

Additional attendees and/or presenters were:

John Abendshien	William T. Foley	Deborah Santana
Michael Ayres	Sara Hynes	Anthony J. Tedeschi, MD, MPH, MBA
Sylvia Edwards	Michael Koetting	
Harold Emahiser	Elizabeth Reidy	Sidney Thomas

II. Public Speakers

Chairman Batts asked the Secretary to call upon the registered speakers.

The Secretary called upon the following registered public speaker:

1. George Blakemore — Concerned Citizen

III. Discussion/Information Items

A. Strategic Planning: Retreat Session
   - i. Opening and Session Objectives
   - ii. Process Overview and Progress Update
   - iii. Review of September 18th Proceedings
   - iv. BREAK
   - v. Draft Vision and Core Goals: Discussion
   - vi. BREAK
   - vii. Strategic Priorities: Discussion
   - viii. Financial Planning Update
   - ix. Next Steps

III. Discussion/Information Items

A. Strategic Planning: Retreat Session (continued)

William T. Foley, System Chief Executive Officer, provided a brief outline of the expectations for the day's meeting. He stated that this is a very important juncture in the strategic planning process, which began in May of this year. John Abendshien and his team from Integrated Clinical Solutions, Inc. have been working hard with System staff to assemble the information and data needed to lay out the parameters of a plan to evaluate and focus upon at this meeting. In addition to information and data, input from stakeholders has been received. He noted that a great amount of input has been received from the various constituency groups from within the System and County; this input was received through responses to questionnaires, meetings with small groups and testimony at public town hall meetings.

Mr. Foley stated that at this meeting, Mr. Abendshien and his team will lay out the framework, vision, core goals, and strategic initiatives. In some cases, there are alternatives that should be discussed at this meeting, so that the Board can come out of the meeting with a basis for a plan. Over the next month, the draft plan can be taken to the various constituency groups to receive input. During that time, the three-year strategic financial plan that will support the strategic plan will be developed, and will be brought to the Board with the final plan for approval.

Mr. Abendshien began the presentation (Attachment #1).

Chairman Batts noted that on page 15 of the presentation, listed as a future goal is for the System to be in the top 50% nationally in patient and caregiver satisfaction levels. He questioned whether their expectations should be higher. Director Zopp suggested that they instead use the term "top quartile".

Director Zopp inquired regarding the section of the language in the draft vision which refers to improving the health of the residents of Cook County. She asked whether it was implicit in that statement that the System will not provide health care to non-residents. Mr. Abendshien responded that providing health care to Cook County residents would be the focus; it would not necessarily restrict the System from providing health care to non-Cook County residents.

The Board continued the discussion on the question of providing care to non-Cook County residents. Director Lyne stated that this is an issue that should be decided. Batts stated that he believed the new patient policies address this issue; non-Cook County residents must pay for these services under the new policies, or services (with the exception of emergency care) will not be provided. In response to Director Greenspan's inquiry regarding the scale of the issue, Michael Koetting stated that although the System does not verify the addresses given, approximately 3-5% of the System's patients are non-Cook County residents.

III. Discussion/Information Items

A. Strategic Planning: Retreat Session (continued)

Michael Ayres, System Chief Financial Officer, provided information as it related to a similar debate during his tenure at the Grady Health System. He offered to draft a narrative of how the topic was addressed at Grady.

Extensive discussion took place on the subject of community hub centers. Mr. Foley stated that a possible suggestion is to have both short-term and long-term plans. In the short-term plan, there could be two or three hubs developed over the next eighteen months. Long-term plans could move towards four to five hubs. In response to a question regarding existing primary care/clinic sites, Mr. Foley stated that he would reach out to the existing federally-qualified health centers (FQHCs), and partner with them on primary care. Director Muñoz stated that it would be wise to look at what type of staffing would be needed for these hubs; there may be shortages in specialties in some localities.

In response to a question from Director Muñoz regarding whether clinics would be feeding into these hubs, Mr. Foley stated that he believes the concept of the whole ACHN network should be reviewed. If the System is going to really focus its resources on the County's needs, can something instead be done to partner with existing primary care clinics, such as the FQHCs?

Chairman Batts polled the Directors on the question of whether this strategic approach should be fleshed-out so that the Board can make a more rational decision. There was unanimous agreement on the question. Director Zopp requested that, as the approach is fleshed-out, information be provided on how this approach impacts what the System is currently doing.

The Board continued to review and discuss the information presented.

The presentation continued to the subject of obstetric services. Mr. Abendshien stated that the Board could go one of two ways: 1) the System could say that they are out of this business, and have the service transfer to other providers; or 2) the System could ramp-up their services to reach a threshold consistent with good operating efficiency and effectiveness (somewhere in the 3000+ delivery range).

The Board discussed the information presented on the provision of obstetric services. Director Carvalho inquired whether Certificate of Need (CON) requirements have been reviewed. Directors O'Donnell and Golden requested more information on the subject. Director Ansell suggested that a two- or three-year strategy be developed; he cautioned against making a quick decision, stating that if the System gets out of that business it will never get it back. With regard to Provident Hospital, Mr. Foley stated that the numbers are so low, he thinks they should stop deliveries there. But from a reimbursement perspective, and being mindful of the System's mission, he stated that he would like to focus on the OB/Gyne at Stroger Hospital. He added that the System should be looking at strategies and relationships like the one with Northwestern, to improve the services.

III. Discussion/Information Items

A. Strategic Planning: Retreat Session (continued)

Sidney Thomas, Chief Operating Officer of Provident Hospital of Cook County, provided examples of past activities and initiatives to increase the number of deliveries at Provident Hospital.

The Board discussed the options relating to the provision of pediatric and perinatal services. It was agreed that there should be further exploration of the idea of collaborating and possibly consolidating these services with other institutions such as Rush Medical Center and UIC Hospital.

Mr. Abendshien continued the presentation, and Mr. Foley reviewed management's recommendations. Specifically discussed were the recommendations regarding the ACHN clinic network, Fantus Clinic and the provision of long-term care services at Oak Forest Hospital.

The Board discussed the proposed strategy of 1) focusing on Oak Forest Hospital as a community hub; 2) building on rehabilitation and phasing-out acute inpatient services; and 3) examining further long-term care/skilled nursing care at Oak Forest Hospital. Harold Emahiser, of Integrated Clinical Solutions, Inc., provided information relating to the decision in 2007 to significantly reduce the long-term care services at Oak Forest Hospital by outsourcing those services, due to the higher cost of providing them on-site. Sylvia Edwards, Chief Operating Officer of Oak Forest Hospital, provided information on the average daily census and the total number of employees at Oak Forest Hospital in 2007.

Mr. Emahiser provided a status update on the process of the three-year financial plan. Chairman Batts requested that the information reflect the breakdown of payer mix. Mr. Foley responded that this can be shown on another schedule.

Mr. Foley reviewed the next steps that are planned. Beginning October 8th, there will be meetings with the County Board President and Commissioners in small groups to review the framework of the plan and to get some additional input. Beginning in the week of October 19th, there will be a second series of town hall meetings to receive input on the draft plan. They will also be meeting with the various constituency groups; these groups include staff, physicians, labor, community groups, and representatives from the FQHCs. The expectation is to bring the plan back to the Board for their November 5th meeting.

IV. Action Items

A. Any item listed under Section III

V. Adjourn

Director Ansell, seconded by Director O'Donnell, moved to adjourn. THE MOTION CARRIED UNANIMOUSLY AND THE MEETING ADJOURNED.

Respectfully submitted,
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXX
Warren L. Batts, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

ATTACHMENT #1

Integrated Clinical Solutions, Inc.

Cook County Health and Hospitals System

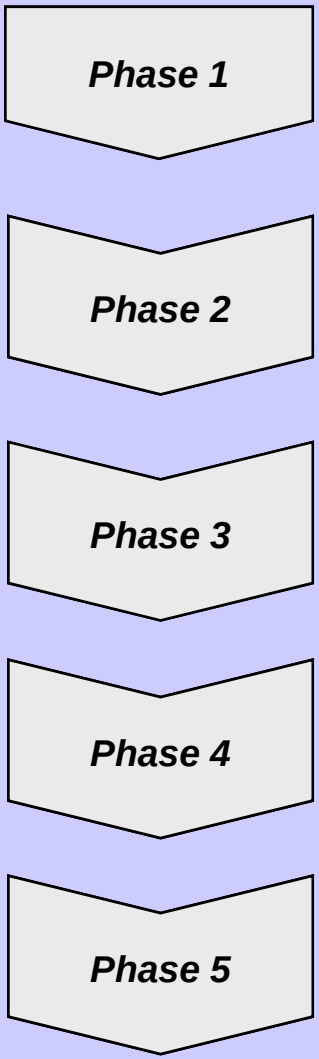
Strategic Planning: VISION + GOAL FRAMEWORK (Board Retreat Discussion Draft)

October 7, 2009

Agenda

- **Process Overview**
- **Desired Future State: Core Themes**
- **Draft Vision**
- **Goals + Strategic Priorities**
- **Next Steps**

Process Overview



Phase 1 – Kick-off & Retreat:

- ***Set the Stage for the Planning Process***

Phase 2 – Discovery:

- ***Evaluate Current Position and Opportunities***

Phase 3 – Strategic Direction:

- ***Develop a Shared Vision and Strategic Direction***

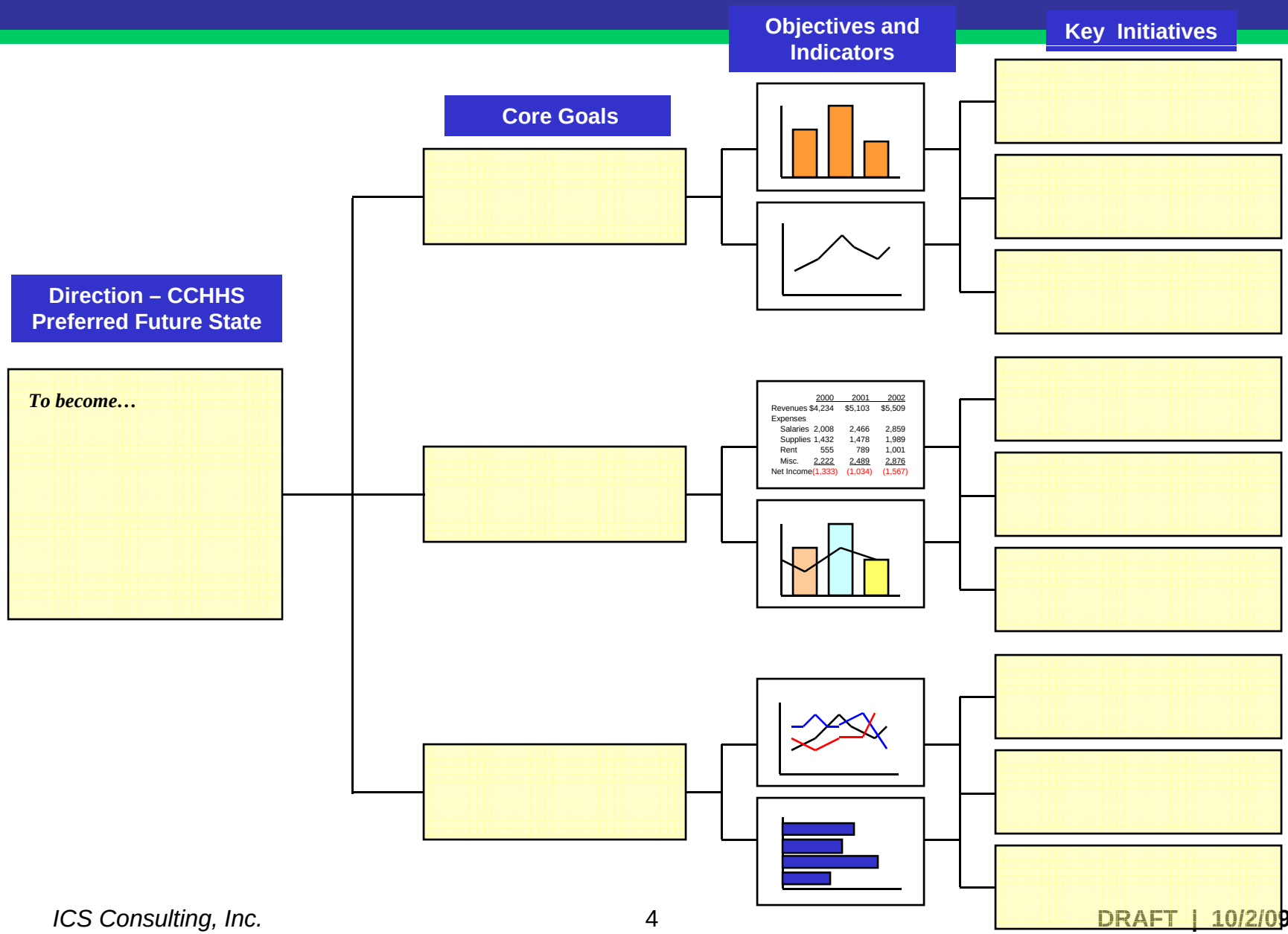
Phase 4 – Financial Plan:

- ***Develop a 3-year Financial Plan***

Phase 5 – Action Plan:

- ***Specify Action Plan and Accountabilities***

Process Outcomes—CCHHS Direction, Focus, and Action



Work in Process

Phase III—Strategic Direction:
Establish Vision & Goals

- Delineate System Design Principles
- Board/Steering Group Retreat
- Formulate Vision and Goals
- Identify Major Strategic Priorities

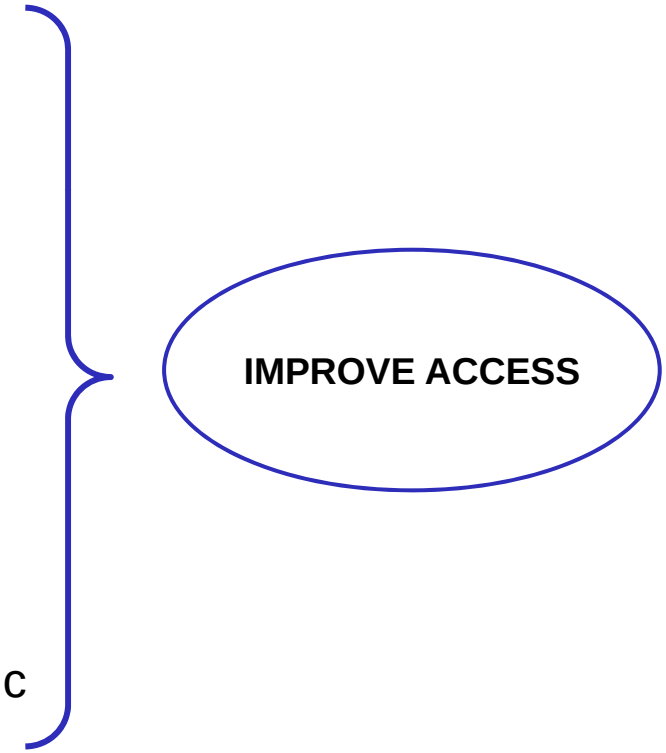
Agenda

- Process Overview
- **Desired Future State: Core Themes**
- Draft Vision
- Goals + Strategic Priorities
- Next Steps

Desired Future State: Core Themes from Discovery Phase

Shared Perceptions of a Desired Future State for CCHHS:
What the System Should "Look Like" in 2012 and Beyond:

- Strategically-distributed geographic access points
- Primary care availability/accessibility (through System resources and/or partnerships)
- Strong specialty care service base
- Sub-regional hubs ("medical home" structures) to support the above
- New (possibly relocated) facilities for services currently housed in Fantus Clinic



Desired Future State: Core Themes (Cont'd.)

Shared Perceptions of a Desired Future State for CCHHS:
What the System Should "Look Like" in 2012 and Beyond:

- Strong focus on screening, early detection, chronic disease management (e.g., diabetes)
- Defined relationships with community provider partners: hospitals, medical schools, FQHC's, other
- Resource/care coordination with collar counties

FOSTER STRATEGIC PARTNERSHIPS

Desired Future State: Core Themes (Cont'd.)

Shared Perceptions of a Desired Future State for CCHHS:
What the System Should "Look Like" in 2012 and Beyond:

- Highly visible and recognized clinical centers of excellence
- Services meet volume thresholds for quality of care, efficiency
- Provident Hospital of Cook County redeveloped for expanded outpatient role (e.g., specialty care, ambulatory surgery)
- Determine best use for Oak Forest Hospital of Cook County facilities: Expand rehab (perhaps in partnership with VA)? Reestablish long-term care? Expand outpatient facilities?

REALIGN SERVICES & SITES

Desired Future State: Core Themes (Cont'd.)

Shared Perceptions of a Desired Future State for CCHHS:
What the System Should "Look Like" in 2012 and Beyond:

- Needs-focused; addresses health issues of residents
- Patient-centered
- Systemized patient care management; care pathways, tracking, and follow-up
- Robust health information technology, including interface of patient care referral/ tracking systems with other entities
- State-of-the-art management functions and processes
- Culture of staff selection, training, and development consistent with ethic of service excellence

FOCUS ON SERVICE EXCELLENCE

Desired Future State: Core Themes (Cont'd.)

Shared Perceptions of a Desired Future State for CCHHS:
What the System Should "Look Like" in 2012 and Beyond:

- Progressive, streamlined approaches to medical staff/employee recruitment and retention
- System branding, marketing, and public relations supports a positive image
- System Board is made permanent and has level of authority/autonomy consistent with challenges the Board is asked to address
- System meets high standards for accountability and stewardship
- A truly integrated System: "a System that functions as a system"

BUILD STAFF AND LEADERSHIP

Major Strategic Issues (discussed at September 18 Board Meeting)

Some Key Questions:

- What is the System all about?
  - Primary care or specialty/tertiary care as primary role?
  - Role of other modalities (e.g., rehabilitation, long-term care)?
  - Geographic distribution of access, care points?
  - Role interface with other providers: community hospitals, public health agencies, FQHC's?
  - Balance between direct provision of care and efforts to coordinate with partner providers of care?
  - Coordination with collar counties?

Major Strategic Issues (Cont'd.)

- Other key questions:
  - Clinical emphasis: centers of excellence?
  - Medical education and research: role and direction?
  - Future role of Provident, Oak Forest, and John H. Stroger, Jr. Hospitals of Cook County?
  - Future of Fantus and related services?
  - Development priorities and sequencing?

Envisioning a Successful Future State

Key Challenges Today

- Significant access barriers
- Limited primary & specialty care resource base
- Facility locations/configuration not conducive to effective System operations
- Fragmented care delivery
- Low patient/caregiver satisfaction
- Staff morale low; recruitment & retention difficult

CCHHS Future State

Envisioning a Successful Future State

Key Challenges Today

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- Staff morale low; recruitment & retention difficult

CCHHS Future State

- Geographically distributed services are highly accessible
- Primary care and specialized needs are met through a combination of County resources and partnerships
- The “right services in the right places”
- Services are patient-centered and fully integrated System-wide
- Patient and caregiver satisfaction levels are in top 50% nationally
- Caregivers are attracted to System; evolving leadership in place

Agenda

- Process Overview
- Desired Future State: Core Themes
- **Draft Vision**
- Goals + Strategic Priorities
- Next Steps

CCHHS Vision + Core Goals (draft)

In recognition of the above envisioned success attributes, the following VISION and CORE GOALS are set forth for the Cook County Health and Hospitals System:

- ***Vision:*** **By 2012, in support of its public health mission, CCHHS will be recognized locally, regionally, and nationally—and by patients and employees—as a progressively evolving model for an accessible, integrated, patient-centered, and fiscally-responsible healthcare system focused on assuring high-quality care and improving the health of the residents of Cook County.**

- ***Core Goals:*** **The above Vision will be attained through:**

  I. Access to Healthcare Services

  II. Program Strength + Partnership

  III. Realignment of Services & Sites

  IV. Quality, Service Excellence & Cultural Competence

  V. Staff & Leadership Development

Strategic Plan: VISION 2012 (draft—for discussion)

Mission

MISSION: To deliver integrated health services with dignity and respect regardless of a patient's ability to pay; foster partnerships with other health providers and communities to enhance the health of the public; and advocate for policies which promote and protect the physical, mental and social well being of the people of Cook County.

Vision 2012

In support of its public health mission, CCHHS will be recognized locally, regionally, and nationally —and by patients and employees—as a progressively evolving model for an accessible, integrated, patient-centered, and fiscally-responsible healthcare system focused on assuring high-quality care and improving the health of the residents of Cook County.

Core Goals	Strategic Initiatives
I. Access to Healthcare Services	• Designate and develop 3-5 geographically-distributed delivery sites as sub-regional "hubs" for provision of a comprehensive range of primary care and specialty outpatient services, as well as preventative and health maintenance services. • Systematically evaluate and remedy System access barriers at all delivery sites: service coverage, scheduling, and physical access.
II. Program Strength + Partnership	• Develop/strengthen Centers of Excellence in needs-based areas such as cancer, cardiac, diabetes, emergency/trauma, rehabilitation, and surgery. • Pursue and support partnerships with academic and community-based providers. • Assure the provision of the Ten Essentials of public health.
III. Realignment of Services & Sites	• Explore options for best long-term usage of Provident Hospital of Cook County (expanded outpatient, specialty services) and Oak Forest Hospital of Cook County (expanded outpatient, rehab.); evaluate options for discontinuing or otherwise restructuring acute inpatient services at these sites. • Rebuild Fantus Clinic, with size appropriate to more distributed outpatient delivery platform.
IV. Quality, Service Excellence & Cultural Competence	• Develop an integrated, System-wide approach and supportive infra-structure for patient-centered care coordination and case management. • Implement a System-wide program of continuous process improvement: patient care quality, safety, and outcomes. • Develop a comprehensive program to instill cultural competency at all sites.
V. Staff & Leadership Development	• Implement range of initiatives to improve caregiver/employee satisfaction. • Focus on streamlined recruiting and retention processes. • Develop a robust program for in-service education and professional skill building; foster leadership development. • Maintain independent governance and professional leadership through extension of CCHHS Board.

Agenda

- Process Overview
- Desired Future State: Core Themes
- Draft Vision
- **Goals + Strategic Priorities**
- Next Steps

Goal I: Access to Healthcare Services

Strategic Priorities

I. Access to Healthcare Services

II. Program Strength + Partnership

III. Realignment of Services & Sites

IV. Quality, Service Excellence & Cultural Competence

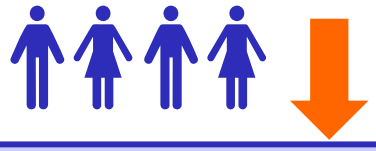
V. Staff & Leadership Development

- **Develop geographically-distributed Community Health "Hub" Centers as sub-regional sites for healthcare delivery and coordination:**
  - Designate 3-5 geographically-accessible sites for Hub Center development. (Consideration may be given to ramping up Provident Hospital of Cook County and Oak Forest Hospital of Cook County sites initially, with other sites designated and developed as the model is implemented and refined.)
  - For each Hub Center, design and implement a full scope of primary and specialty care services that encompass:
    - Routine primary care
    - Walk-in/urgent care
    - Rotating specialty care
    - Ambulatory surgery
    - Observation beds
    - Other: e.g., screening, prevention, oral health, ophthalmology, mental health
    - (NOTE: certain of the above services—e.g., oral health, mental health—may be provided through agreements with other agencies, but co-located with County Hub Center sites.)

Comprehensive Community Health Center

Conceptual development of a "typical" Hub Center...

Patients



Urgent Care/ Walk-In Care	**Routine Primary Care**	**Outpatient Surgery**	**Rotating Specialists**
23-Hour Stay (selected sites)	**Preventive Medicine**	**Oral Health Mental Health**	**Health Education**

Physician and Support Staffing

Primary Care: Family Practice/ Internal Medicine

Rotating Specialists: (as appropriate)

Support Staffing: Reception, Medical Assistant, Add PRN, plus ASC staff

Space and Ancillary Facilities

Walk-In/Urgent Care, Physician Exam/Treatment Rooms, Basic Lab, X-Ray, CT, MRI, Fluoro., Bone Densitometry, Physical Therapy, Outpatient Surgery, Community Conference Center

IT Platform & Telemedicine

Hospital

Goal I: Access to Healthcare Services

Strategic Priorities

I. Access to Healthcare Services

II. Program Strength + Partnership

III. Realignment of Services & Sites

IV. Quality, Service Excellence & Cultural Competence

V. Staff & Leadership Development

- **Systematically identify, evaluate, and remedy (as appropriate) System barriers to access where there are service gaps and/or protracted delays in receiving services.**
  - Services identified as posing access barriers include (but are not limited to):
    - Anti-coagulation services
    - Asthma/COPD care
    - Cancer services
    - Diabetes care
    - Endoscopy
    - General surgery
    - GYN services (elective)
    - Hand surgery
    - Joints (diagnostic & replacement services)
    - Mammography
    - Mental health services
    - Oral surgery/oral health

Goal I: Access to Healthcare Services

Strategic Priorities

I. Access to Healthcare Services

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- Services identified as posing access barriers (continued):
  - Palliative care
  - Primary care (overall)
  - Specialty consultation (outpatient)
  - Urgent care (especially off-hour access)
  - Vascular access (shunts for hemodialysis)

- **Develop focused strategies and initiatives to optimize usage of the Emergency Department at John H. Stroger, Jr. Hospital of Cook County, e.g.:**
  - Aggressive targets and supportive strategies for reducing wait times in the ED
  - Timeliness and functionality of Urgent Care services
  - Availability of specialty services
  - Elimination of unnecessary admissions from the ED

Goal I: Access to Healthcare Services

Strategic Priorities

I. Access to Healthcare Services

II. Program Strength + Partnership

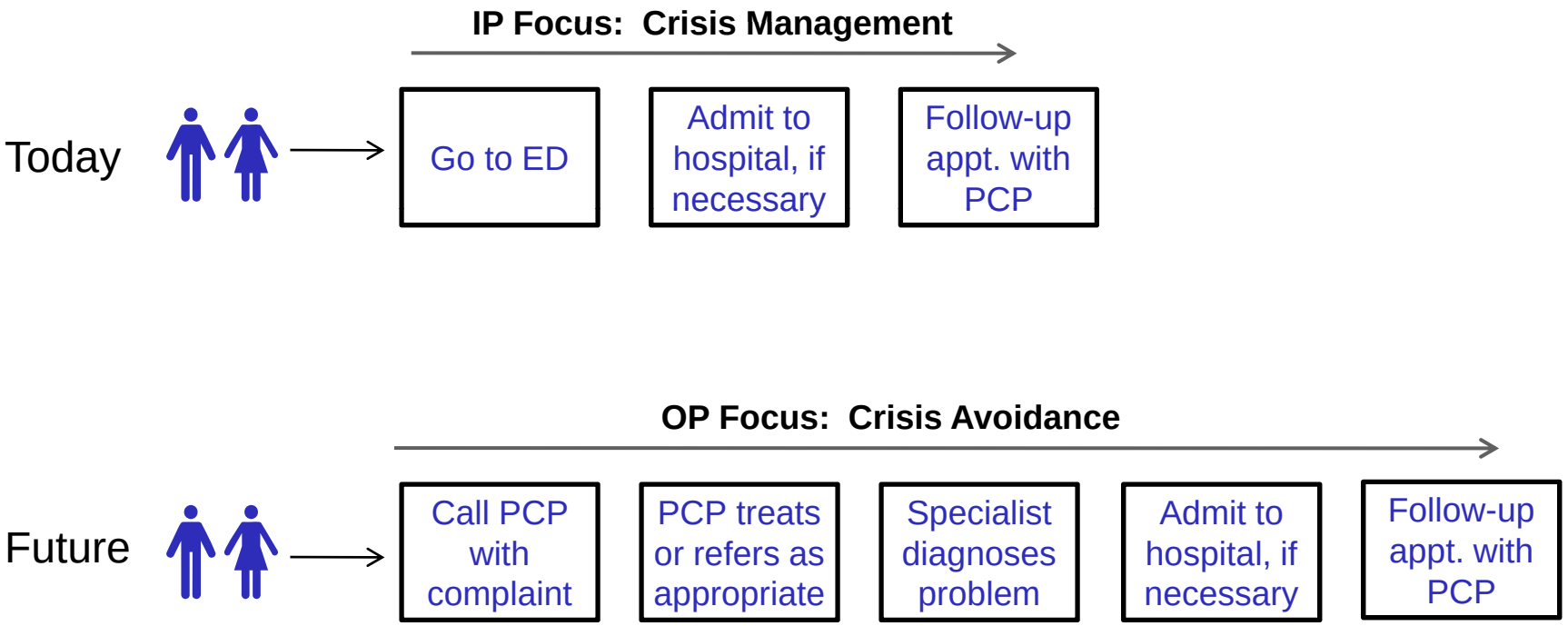
III. Realignment of Services & Sites

IV. Quality, Service Excellence & Cultural Competence

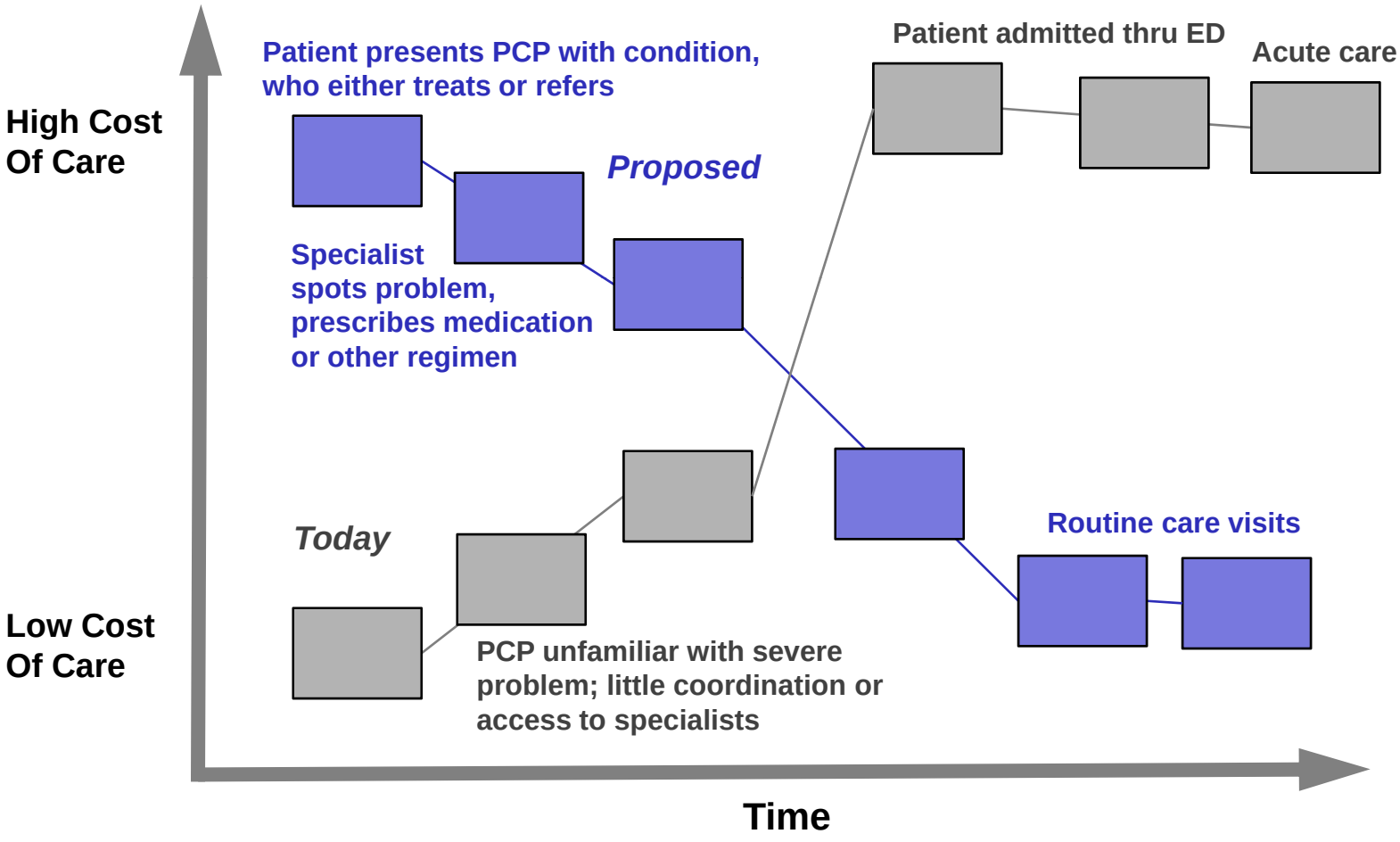
V. Staff & Leadership Development

- **Conduct a comprehensive review of physical access issues at the John H. Stroger, Jr. Hospital of Cook County campus; develop specific plans and timetables to remedy major access barriers such as:**
  - Parking
  - Elderly/handicapped access
  - Overall signage, way-finding

Managing cost and quality through coordinated care and better PCP access—EXAMPLE



Managing cost and quality through better specialty access



Goal II: Program Strength + Partnership

Strategic Priorities

I. Access to Healthcare Services

II. Program Strength + Partnership

III. Realignment of Services & Sites

IV. Quality, Service Excellence & Cultural Competence

V. Staff & Leadership Development

- **Develop focused Centers of Excellence in specific programmatic areas that (a) meet defined community needs; (b) are integral to the continuum of care provided by the System, and/or (c) have the potential to be truly distinctive in terms of intellectual and clinical leadership in the medical community.**
- **Based on the above criteria, consider maintaining, enhancing, or developing the following Centers of Excellence:**
  - Asthma/COPD
  - Cancer Services
  - Cardiac Services
  - Communicable Diseases/HIV
  - Diabetes Care
  - Emergency/Trauma/Critical Care
  - Emergency Preparedness
  - Primary Care/Ambulatory Specialty Care (incl. Urgent Care)
  - Rehabilitation/Long-term Care
  - Surgical Services

Goal II: Program Strength + Partnership

Strategic Priorities

I. Access to Healthcare Services

II. Program Strength + Partnership

III. Realignment of Services & Sites

IV. Quality, Service Excellence & Cultural Competence

V. Staff & Leadership Development

- **For identified Centers of Excellence, develop an "Institute" approach that emphasizes:**
  - Leading edge research, innovation, and development
  - Collaboration with selected academic health centers/community health systems
  - Alignment of education and research endeavors
  - Joint research and collaboration with national leaders in respective areas
  - Differentiated in the market—able to attract referrals from the private healthcare sector
  - Branding and marketing
  - Broad-based referrals from outside the System
  - External funding, including grants and philanthropic sources

Goal II: Program Strength + Partnership

Strategic Priorities

I. Access to Healthcare Services

II. Program Strength + Partnership

III. Realignment of Services & Sites

IV. Quality, Service Excellence & Cultural Competence

V. Staff & Leadership Development

- **Continue to strengthen/build upon other services critical to the needs of the population served,** including "life-quality-enhancing" services such as:
  - Dental/oral health
  - Mental health
  - Ophthalmology
  - Orthopedics, including joint surgery
  - Pain management
  - Podiatry
  - Preventative health

Goal II: Program Strength + Partnership

Strategic Priorities

I. Access to Healthcare Services

II. Program Strength + Partnership

III. Realignment of Services & Sites

IV. Quality, Service Excellence & Cultural Competence

V. Staff & Leadership Development

- **Evaluate options for provision of obstetrical and perinatal services:**
  - Current volumes at both John H. Stroger, Jr. and Provident Hospitals of Cook County do not meet threshold levels needed for proficient, cost-effective services, accordingly…
  - Options should be explored to either (a) significantly expand delivery volumes (3,000-5,000+ deliveries at one site, ideally in partnership with other medical entities), or (b) if significant growth of the service is not attainable or consistent with best use of County resources, pursue partnership arrangements with outside provider systems for the provision of OB services through service and transfer agreements.
  - Obstetrical services at Provident Hospital of Cook County should be discontinued, with deliveries coordinated through service and transfer agreements.
  - In any case, CCHHS should continue to provide pre- and post-natal care, and should further build on GYN and women's services, including services geared to the needs of the peri-menopausal female population.

Goal II: Program Strength + Partnership

Strategic Priorities

I. Access to Healthcare Services

II. Program Strength + Partnership

III. Realignment of Services & Sites

IV. Quality, Service Excellence & Cultural Competence

V. Staff & Leadership Development

- **Evaluate options for provision of neonatal intensive care and general pediatric services:**
  - Pediatric and neonatal services at John H. Stroger, Jr. Hospital of Cook County have not been operating at volume thresholds deemed optimal for high-quality, efficient operations.
  - Given the above, consideration should be given to joint planning with Rush Medical Center, UIC Hospital, and possibly other institutions to explore options and identify the optimal approach for provision of pediatric and NICU delivery capabilities to the uninsured population as well as other County residents. Specific options may include:
    - Consolidation of services
    - Integrated residencies
    - Joint, co-branded operations

Goal II: Program Strength + Partnership

Strategic Priorities

I. Access to Healthcare Services

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III. Realignment of Services & Sites

IV. Quality, Service Excellence & Cultural Competence

V. Staff & Leadership Development

- **Continue to support and strengthen the System's role in medical education and research; develop a policy framework that guides decision-making and priority-setting that is based upon:**
  - Consistency with/support of program development priorities
  - Staffing coverage
  - Staffing costs/benefits
  - Reimbursement
  - Grants and other external funding
  - Impact on recruiting
- **Continue to implement initiatives at Cermak facility to regain accreditation and come into compliance with clinical goals and applicable requirements.**

Goal II: Program Strength + Partnership

I. Access to Healthcare Services

II. Program Strength + Partnership

III. Realignment of Services & Sites

IV. Quality, Service Excellence & Cultural Competence

V. Staff & Leadership Development

Strategic Priorities

- **Proactively pursue and support partnerships with academic and community-based healthcare provider organizations to complement and strengthen program development, and expand staff capability.**
  - *Program Collaboration*: Partnership in program development, teaching, and research in Centers of Excellence.
  - *Geographic Coverage*: Relationships with FQHC's and other community providers to extend services to selected community settings.
  - *Physician Staffing*: Service agreements with academic and community-based providers to supplement CCHHS physician staffing with primary care physicians and specialists at the various CCHHS sites.
  - *Prevention and Related Public Health Services*: Joint service development with County Department of Public Health and, as appropriate, City/State public health agencies to provide prevention services, information, and education services as part of Hub Center model.

Goal II: Program Strength + Partnership

I. Access to Healthcare Services

II. Program Strength + Partnership

III. Realignment of Services & Sites

IV. Quality, Service Excellence & Cultural Competence

V. Staff & Leadership Development

Strategic Priorities

- **Work closely with providers in service partnership arrangements to ensure that appropriate care coordination and transitioning systems and processes are in place:**
  - Service and Transfer Agreements: Provision of services in instances where it is not operationally feasible or cost-effective for CCHHS to do so
  - Care coordination/patient case management: All providers/provider systems who are partnering in the provision of care are part of single, rule-based referral and service coordination system (IRIS):
    - Clearinghouse for provider information
    - Patient information
    - Referral information and coordination
    - Results monitoring

Goal III: Realignment of Services & Sites

I. Access to Healthcare Services

II. Program Strength + Partnership

III. Realignment of Services & Sites

IV. Quality, Service Excellence & Cultural Competence

V. Staff & Leadership Development

Strategic Priorities

- **Consistent with program objectives, conduct a comprehensive review of CCHHS facilities and sites to determine how the System infrastructure can best support development priorities:**
  - **ACHN Clinics**:
    - Designate and develop selected clinic sites as Community Health Hub Centers where such sites are strategically located and support expanded development.
    - Evaluate non-Hub sites re: opportunities for expanded services and volumes, including opportunities for partnerships with FQHC's and other provider organizations.
    - Conduct a comprehensive facility review of all clinic sites to assess efficiency, space, functional, equipment, and code compliance issues.
  - **Fantus Clinic**:
    - Plan for near-term replacement of Fantus Clinic facilities, taking into consideration potential downsized needs as Hub centers assume more of the System's outpatient role.
    - In the short-term, evaluate options for reengineering Urgent Care systems and processes, including coordination with ED.

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- **Site development priorities (cont'd):**
  - **Oak Forest Hospital of Cook County:**
    - Expand outpatient role as Community Hub Center.
    - Continue/build upon role as Rehabilitation Center; explore partnership opportunities with VA and other health systems.
    - Phase out acute inpatient services, given size of services and limitations of physical facilities
    - Explore service linkage with existing health systems for the provision of acute inpatient care services in the Far South market, if it is determined that inpatient capacity is needed to serve County patients in this market.

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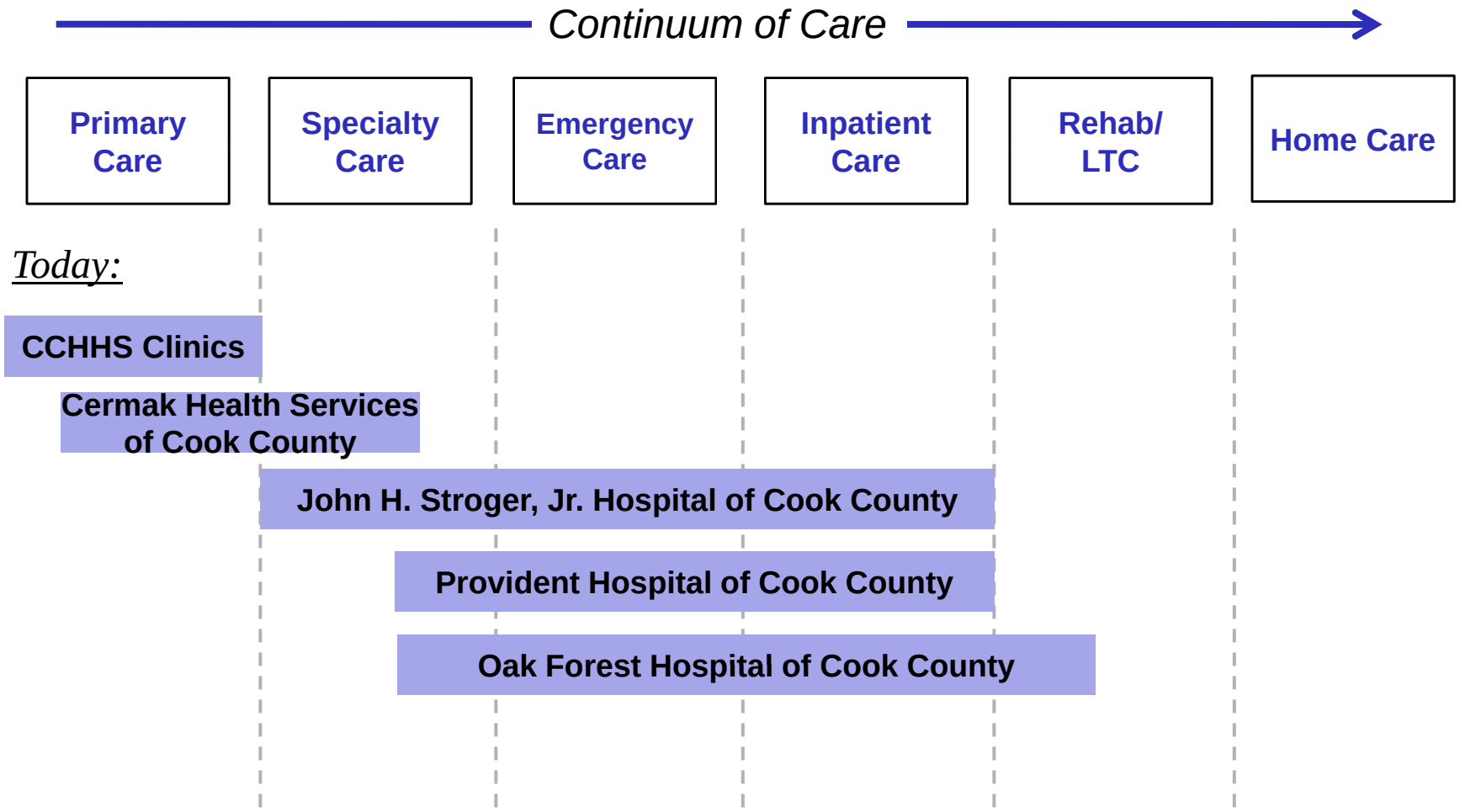
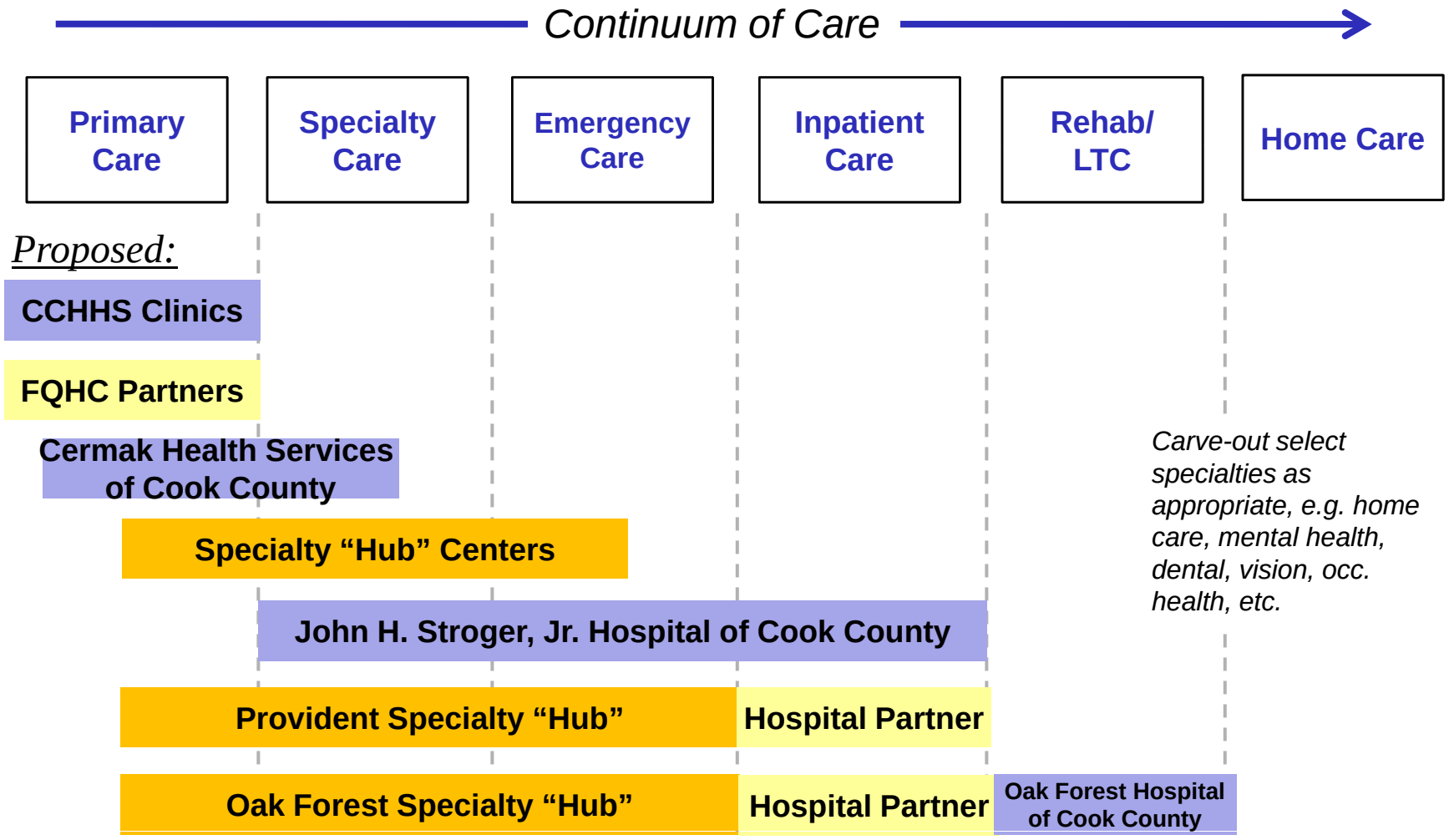
Strategic Priorities

- **Site development priorities (cont'd):**
  - **Provident Hospital of Cook County:**
    - Redevelop Provident Hospital of Cook County as a comprehensive Community Hub Center, along with an expanded role in the provision of specialty care services, outpatient surgery, and comprehensive diagnostic and treatment services.
    - Evaluate options for acute inpatient care: (a) discontinue acute inpatient care operations; or (b) as part of a clinical (and economic) partnership with U of C Medical Center, consider expansion of acute inpatient care services.
  - **John H. Stroger, Jr. Hospital of Cook County:**
    - Continue/strengthen role as the System's inpatient facility, serving as a major County resource for emergency/trauma care as well as specialty inpatient and outpatient services.
    - Develop a comprehensive site plan to address parking and circulation issues.
    - Develop a plan for equipment replacement and technology upgrades.

The CCHHS across the continuum of care, today



The CCHHS across the continuum of care, proposed



Goal IV: Quality + Service Excellence + Cultural Competence

Strategic Priorities

I. Access to Healthcare Services

II. Program Strength + Partnership

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IV. Quality, Service Excellence & Cultural Competence

V. Staff & Leadership Development

- **Commit to and support a culture of deliberate and continuous improvement—patient care quality, safety, and teamwork:**
  - Ensure that quality expectations, targets, and measures are defined and fully communicated.
  - Provide data-driven feedback loops to support continuous quality improvement.
  - Instill a team versus silo mindset, with individuals accountable for team performance and overall outcomes.
  - Reinforce the use of evidence-based methodologies throughout the clinical enterprise
  - Ensure that the full range of quality management functions are focused on patient safety, service quality, performance improvement, and compliance.
  - Monitor and publish patient quality/safety indicators (disease-specific quality measures—also include System-wide measures such as mortality rate, infections, readmission rates, medication errors, patient falls, etc.)
  - Emphasize and report on specific patient safety and quality measures, such as medication reconciliation, surgery-related infection control, hand washing, preventing falls, etc.

Goal IV: Quality + Service Excellence + Cultural Competence

I. Access to Healthcare Services

II. Program Strength + Partnership

III. Realignment of Services & Sites

IV. Quality, Service Excellence & Cultural Competence

V. Staff & Leadership Development

Strategic Priorities

- **Institute a System-wide approach to collaborative and coordinated patient case management:**
  - *Coordinated Care and Transitions*: Patient care is coordinated in a manner that the patient "is in the right place at the right time," regardless of geographic origin and entry point into the System; transfers and transitions across sites and care settings are effectively managed.
  - *Medical Homes as Coordination Centers*: Patients coming into the System, regardless of entry portal, select (or are assigned) a Medical Home based at a Hub Center for post-intervention follow-up and ongoing care coordination/management processes.
  - *Flow of Information*: All relevant patient clinical information is available at the point of care delivery; IT and telemedicine platforms support treatment and care coordination across the System and with the System's clinical partners.
  - *Interface with Provider Partners*: All providers/provider systems who are partnering in the provision of care are part of single, rule-based referral and service coordination system (IRIS). (See Goal III, above.)
  - *Accountability for Outcomes*: Outcome measures are available and monitored for the total episode of care.

Goal IV: Quality + Service Excellence + Cultural Competence

Strategic Priorities

I. Access to Healthcare Services

II. Program Strength + Partnership

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V. Staff & Leadership Development

- **Identify key patient dissatisfiers on a System-wide basis; systematically develop processes, systems, and facilities to address issues related to:**
  - Access
  - Wait times
  - Environmental safety and ambiance
- **Continue to develop/strengthen programs and processes designed to ensure successful interactions with patients from various ethnic and cultural backgrounds:**
  - On-site interpreter services
  - Health information geared to language and cultural norms of population groups
  - Diversity of staff
  - Cross-cultural training and professional development
  - Language-appropriate survey methodology
  - Monitoring of medical errors that may be due to language barriers

Goal V: Staff & Leadership Development

Strategic Priorities

I. Access to Healthcare Services

II. Program Strength + Partnership

III. Realignment of Services & Sites

IV. Quality, Service Excellence & Cultural Competence

V. Staff & Leadership Development

- **Develop a System-wide plan for identifying staffing needs and recruitment priorities for all sites/levels of the organization:**
  - Physicians, by specialty, by site
  - RN's
  - Other allied health professionals and caregivers
- **Focus on "values-based" processes for recruiting, training, evaluation, and leadership development; e.g.:**
  - Compatibility with CCHHS Mission, values
  - Baseline abilities and potential for learning, growth
  - Team orientation
- **Reinforce the commitment to staff training and development through:**
  - Comprehensive in-service training and related requirements for CCHHS staff
- **Systematically identify and remedy systemic barriers to effective recruiting process:**
  - Streamline processes, communications, and turnaround times

Goal V: Staff & Leadership Development

Strategic Priorities

I. Access to Healthcare Services

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V. Staff & Leadership Development

- **Focus on alignment of staff skill sets with actual job requirements:**
  - Recruitment, training, and ongoing in-service education for caregiver specialists in specific disciplines and disease-specific areas, where appropriate
  - Elimination of cross-staffing where backgrounds and skills are not suited to applications, and conversely…
  - Elimination of job classifications that are too narrowly-defined
- **Maximize the use of non-physician providers in the various CCHHS delivery settings, where appropriate.**
- **Develop/implement comprehensive employee performance evaluation and feedback systems, at all System levels and sites.**
- **Review and upgrade the performance of department-level supervision overall:**
  - Identification of applicable skill sets and performance criteria
  - In-service education and/or personnel changes, as needed

Goal V: Staff & Leadership Development

Strategic Priorities

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V. Staff & Leadership Development

- **Develop a workplace environment and support structure that attracts, develops, reinforces, and retains top-notch employees who support the mission and vision of CCHHS:**
  - Target and achieve overall employee satisfaction score of at least 70-80%, with percentage of those who rate CCHHS as "a good place to work" in the top quartile nationally.
- **Focus on leadership development and succession planning:**
  - Put in place processes and measures to evaluate and enhance the performance of clinical and executive leadership—defined goals, evaluations, feedback, and leadership training.
  - Identify and nurture "clinical champions"—the physician leaders of today and tomorrow.
- **Encourage open communication, collaboration, and teamwork at all levels of the System:**
  - Clear communication of System Vision and overall direction
  - Open communications and collaboration in decision-making
  - Support of risk-taking and flexibility to make mid-course corrections

Goal V: Staff & Leadership Development

Strategic Priorities

I. Access to Healthcare Services

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V. Staff & Leadership Development

- **Review, reaffirm, and refine the ongoing roles and responsibilities of the CCHHS Board:**
  - Critical importance of continuing Board involvement and role over the long-term, given the scope of needed change and need for ongoing accountability and stewardship
  - Importance of performance targets, timetables, and Board role in monitoring same
  - Need for substantial governance autonomy to make critical decisions re: overall direction, budgeting, and allocations of resources

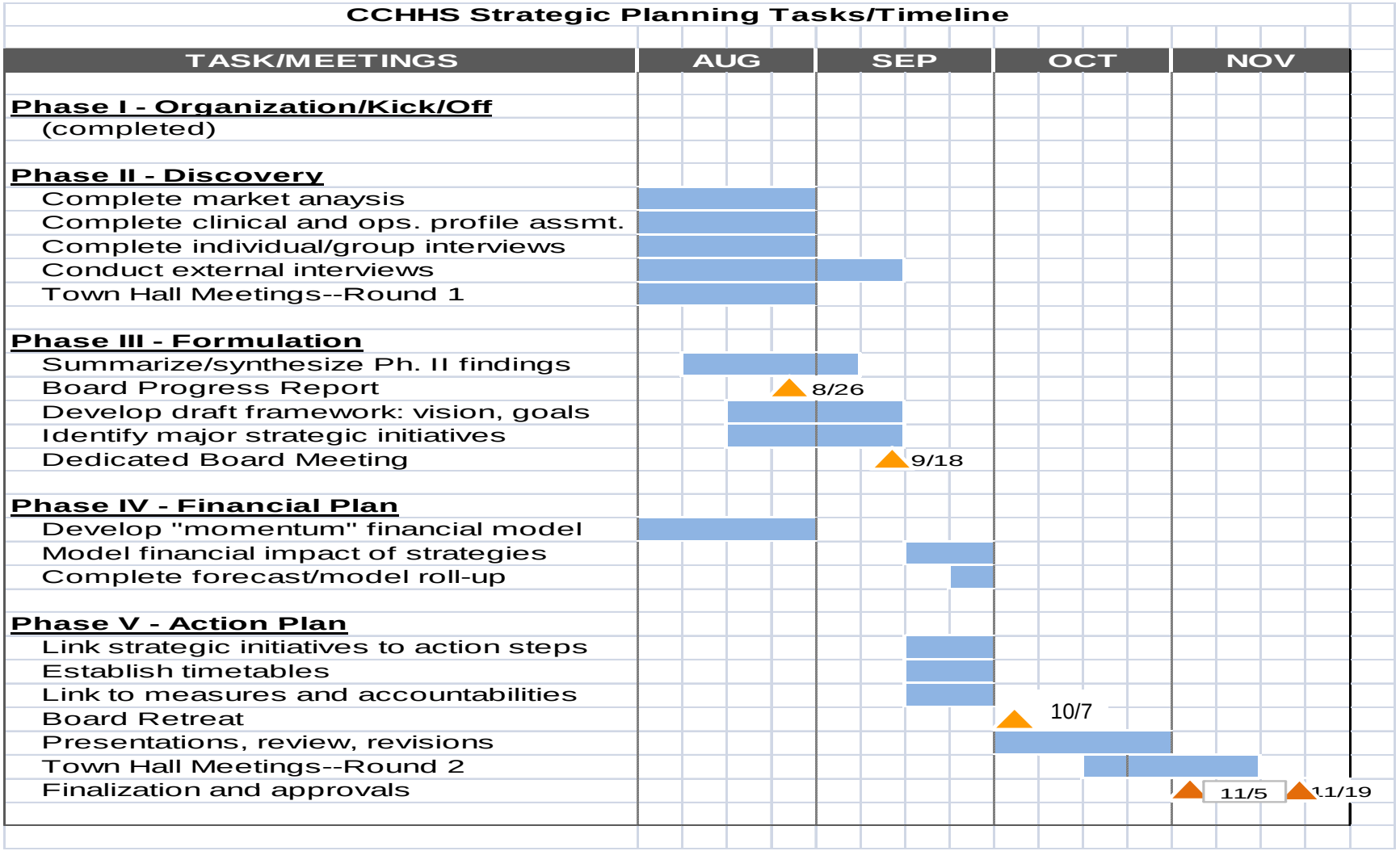
Agenda

- Process Overview
- Desired Future State: Core Themes
- Draft Vision
- Goals + Strategic Priorities
- **Next Steps**

Next Steps

- Refinement of VISION, GOALS, AND STRATEGIC PRIORITIES based on Board review
- Town Hall meetings
- Meetings with various internal, external constituency groups
- Completion of 3-year FINANCIAL PLAN
- Development of ACTION PLANS
- Final revisions
- Board approval

Tasks & Timelines



Cook County Health and Hospitals System of Illinois
Forecasted Cash Sources and Cash Uses, FY2010 - 2012

	Annual, in 000's					Comments
	FY08	FY09	FY10	FY11	FY12	
	Actual	Actual/ Forecasted	Forecasted	Forecasted	Forecasted	
Operating revenue						
Patient Service Revenue	$ 279,006	$ 240,012	$ 247,213	$ 254,629	$ 262,268	Assumes 3% trend factor
FMAP	-	36,000	38,582	-	-	Assumes stimulus money through 2010
Inter-Governmental Transfers (IGT)	127,270	131,250	131,250	131,250	131,250	Held flat
NetDSH	-	225,000	150,000	150,000	150,000	2009 has retro DSH for 2009 and 2008
Total Patient Service Revenue	406,276	632,262	567,044	535,879	543,518	
Other revenue	6,184	3,559	3,569	3,676	3,786	Assumes 3% trend factor
Total operating revenue	412,460	635,821	570,613	539,555	547,304	Normalized DSH and phasing out stimulus money.
Operating expenses						
Salaries and wages	491,704	509,897	526,138	541,922	558,180	Assumes 3% trend factor
Employee benefits (Excludes Pension Expense)	88,111	72,507	74,922	77,169	79,484	Assumes 3% trend factor
Pension Expense	90,443	65,416	67,378	69,400	71,482	Assumes 3% trend factor
Supplies	137,476	148,126	145,414	149,776	154,269	Assumes 3% trend factor, new items per budget
Purchased services, rental and other	117,155	145,425	206,267	212,455	206,829	Assumes 3% trend factor, new items per budget
Depreciation	47,484	41,880	41,881	41,881	41,881	Held flat
Utilities	17,647	17,054	17,831	18,366	18,917	Assumes 3% trend factor
Services contributed by other County offices	6,393	4,035	4,177	4,303	4,432	Assumes 3% trend factor
Total operating expenses	996,413	1,004,339	1,084,007	1,115,271	1,135,473	
Operating Loss	**(583,953)**	**(368,518)**	**(513,394)**	**(575,716)**	**(588,169)**	**Margin erosion year over year**
Adjustments for cash basis						
Pension	90,443	65,416	67,378	69,400	71,482	Add back, not in budget
Malpractice	-	-	-	-	-	Add back, not in budget
Depreciation	47,484	41,880	41,881	41,881	41,881	Add back, not in budget
Employee benefits	88,111	72,507	74,922	77,169	79,484	Add back, not in budget
Capital investment	-	(35,753)	(36,019)	(37,820)	(39,711)	Only operational capital, exlcudes strategic
Dept of Health	(13,679)	(12,834)	(15,124)	(15,577)	(16,043)	Same assumptions as other entities.
Net Subsidy Requirement, Baseline	**(371,594)**	**(237,302)**	**(380,356)**	**(440,663)**	**(451,076)**	
Performance Improvement Initiatives						
Productivity			18,156	22,881	23,567	Assumes 444 FTE reduction.
Supply Chain			10,187	8,500	9,142	Some one time pick ups in FY10.
Revenue Cycle			12,000	12,500	13,000	Currently achieving targets.
Total Subsidy Requirement Prior to Strategic Plan	**$ (371,594)**	**$ (237,302)**	**$ (340,013)**	**$ (396,782)**	**$ (405,366)**	
Strategic Plan			*(30,000)*			Per 2010 budget, later years pending stratgic plan.
Net Subsidy Requirement, after Initiatives	**$ (371,594)**	**$ (237,302)**	**$ (370,013)**	**$ (396,782)**	**$ (405,366)**	